Ontario
North East Local Health Integration Network
Réseau local d'intégration des services de santé du Nord-Est

North East CCAC CASC
Community Care Access Centre
Centre d'accès aux soins communautaires du Nord-Est

ConnexOntario
Health Services Information
Information sur les services de santé

thehealthline.ca

Community Mental Health and Addictions Services Referral Form

IF THIS IS AN EMERGENCY, CALL 911 OR YOUR LOCAL CRISIS SERVICES

If Faxed Include Number of Pages (Including Cover):_______ **Date of Referral ____________**

Identifying Information for Person Being Referred

Last Name: ____ First Name: ____

Preferred/Alternate Name: ____

Date of Birth: _________ Age:_____ Gender:______________ Aboriginal Status: ______________________________

Health Card #:________________________ Version Code: ____ Province Issuing Health Card: ___________________

☐ No Health Card ☐ No Version Code

Current Address:____ City:_______________________ Province: _____________

Postal Code:____________ ☐ No known address

Telephone:_______________ ext:_____ Alternate Telephone:__________ext.:______ ☐ No known telephone

Language first spoken: ☐ English ☐ French ☐ Other (specify): ___________________________________

In which of language is person being referred most comfortable? ☐ English ☐ French ☐ Other

Name of Alternate Contact Person:____ OK to contact if required? ☐ Yes ☐ No

Telephone:______________ ext.:______ Cell No.: ______________

Relationship to person referred (check all that apply): ☐ Power of Attorney ☐ Substitute Decision Maker

☐ Spouse ☐ Family Member ☐ Friend ☐ Case Worker ☐ Elder ☐ Other: (specify)______________________

Address for services (if different than Home Address): ____

City:______________________________ Province:_____________ Postal Code: __________

Telephone:____________ ext.______Alternate Telephone:______________ext.:______ ☐ No known telephone

Contact Information

Conduct call back with: ☐ Person being referred Best time to call:_______________ OK to leave message? Yes No

(Check all that apply) ☐ Alternate Contact Best time to call:_______________ OK to leave message? Yes No

☐ Person being referred wishes to be contacted by email - Email address: ______________________________

Please check all accessibility or functional challenge(s) the referral recipient(s) should be aware of:

☐ Interpreter required ☐ Cognitive ☐ Literacy ☐ Physical/Mobility ☐ Hearing ☐ Visual ☐ Other: ___________________________

Details: ____

Current Agencies/Services Involved: ____

Referral Source

Name:__________________________ Role/Title:____________Organization:____________________________

Telephone:_____________ ext.:________ Fax #: _______________

Relationship to person being referred: ☐ Self ☐ Spouse ☐ Family ☐ Friend ☐ Agency ☐ Care Provider ☐ Other

Is the person being referred aware of the referral? ☐ Yes ☐ No

☐ The person being referred consented to the referral. Date consent provided:______________

☐ Acknowledgement of referral receipt requested by referring agency.

This form contains personal health information that is subject to the provisions of the *Personal Health Information Protection Act.* The information is collected for the purpose of referring patients to local mental health and addictions agencies which offer services that may benefit them. Mental Health and Addictions agencies will only use the information to assess patient eligibility and arrange services as required.

Referral for: Last Name:______________________________ First Name: ____

Psychiatric Information

Does the person being referred have a psychiatric diagnosis? ☐ Yes ☐ No ☐Unknown

If yes, what is the diagnosis? ____

Is the person being referred currently receiving care from a psychiatrist? ☐ Yes ☐ No ☐Unknown

If yes, name of Psychiatrist:___________________________ ☐ Unknown

Telephone______________ext.:______ ☐Unknown Fax #:_________________________ ☐Unknown

Medical Care Provider Information

Is the person being referred currently receiving care from a family doctor or nurse practitioner? ☐ Yes ☐ No ☐ Unknown

Name of family doctor or nurse practitioner:______________________________ ☐ Same as referral source ☐ Unknown

Telephone____________ ext.:_____ ☐Unknown Fax #: ______________________ ☐ Unknown

Requested Services – Check all that apply

Reason for Referral(s): ____

☐Mental Health

- ☐Child and Youth
- ☐Seniors Mental Health
- ☐Family
- ☐Legal / Court
- ☐Sexual Assault / Domestic Violence
- ☐Peer Support
- ☐Housing
- ☐Social / Rehabilitation Support
- ☐Concurrent Disorder
- ☐Case Management
- ☐Dual Diagnosis
- ☐Eating Disorder
- ☐Early Psychosis
- ☐Other (please specify in details section below)

☐Addictions or Substance Abuse

- ☐Child and Youth
- ☐Family
- ☐Assessment
- ☐Withdrawal Management
- ☐Outpatient Treatment
- ☐Residential Treatment
- ☐Supportive Housing
- ☐Alcohol
- ☐Drugs
- ☐Opiates
- ☐Gambling
- ☐Case Management
- ☐Other (please specify in details section below)

☐Psychiatric Consult (physician or NP referral only) Billing # _________________________

- ☐Consultation/Assessment
- ☐Diagnosis
- ☐Medication Management

Additional Details:____

____

____

Additional Information and Referral Attachments

Additional information attached or to follow ☐Yes ☐No

☐Diagnosis note ☐ Assessment note ☐ Medications ☐ Other: ____

Any current medical concerns?	Yes	No	Unknown	Details:______________________________
Pregnant or recent childbirth?	Yes	No	Unknown	Details:______________________________
Currently on medication(s)?	Yes	No	Unknown	Details:______________________________
Any current legal issues?	Yes	No	Unknown	Details:______________________________
History of aggressive behavior?	**Yes**	**No**	**Unknown**	**Details:______________________________**

For receiving agency use only

Date/time referral received:___________________________ Date/time client assessed: ______________________________________

Date/time client on service: ___________________________

This form contains personal health information that is subject to the provisions of the *Personal Health Information Protection Act.* The information is collected for the purpose of referring patients to local mental health and addictions agencies which offer services that may benefit them. Mental Health and Addictions agencies will only use the information to assess patient eligibility and arrange services as required.

North East Ontario

North East Connect Referral Contact Information

Service Referral Information:
Family Care Pharmacy - Iroquois Falls - Benzodiazepine Use Disorder Program
125 Ambridge Dr, Iroquois Falls, ON, P0K 1G0
Referral Contact: